PRINTED: 06/09/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING _____ B. WING _____	C 05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 15, 2011 through May 26 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 59. The survey Stage II sample totaled twenty-nine (29) residents.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156	F156 R37 was originally admitted to the facility through a respite agreement with Delaware Hospice. The family of R37 has been advised verbally of her rights to Medicare and Medicaid since permanent residency has been established. Information and Medicaid application is now included in the standard admission packet. Medicare eligibility information is also included in the admission packet. Other residents may be affected by their lack of knowledge of the Medicaid process and information and applications are available in the Business Office. The Business Office Manager (E20) has received education on the inclusion of Medicaid and Medicare information in the admissions packet. The Administrator or designee will monitor the admissions packets and variances will be reported to the Quality Assurance Committee.	7/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/28/11

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 (i)(A) and (B) of this section.	F 156		

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance

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F 156	Continued From page 2	F 156		

directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on review of facility documentation and interviews, it was determined that the facility failed to provide Medicaid/Medicare information to residents and responsible parties upon admission. Findings include:

Interview with R37's responsible family member on 5/17/11 at 11:17 AM revealed that she

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F 156	Continued From page 3 received an admission package when R37 was first admitted yet the packet was missing the information on how to apply for Medicaid or Medicare. Record review revealed R37 was admitted to the facility on 10/11/10 for physical therapy and was on Medicare A and had a private medical insurance. Record review for R37 revealed that the responsible party (POA) family member received an admission packet and signed different documents which included the laboratory agreement, activity consent, photograph release, laundry/clothing requirements and the pharmacy agreement. Information on Medicaid or Medicare was not found in the medical record. Review of the facility admission packet revealed the Medicaid or Medicare information missing from the packet. Interview with E20 (Business Manager) on 5/24/11 at 10:10 AM revealed that she did not review Medicaid or Medicare information with the resident or responsible party unless they brought it up to her during admission or prior to the resident's admission. She stated that most residents were private pay and recently had admitted only a few people on Medicaid. On 5/24/11, E20 stated that she had not included information on Medicaid or Medicare in the admission packet and confirmed this finding.	F 156		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164		

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F 164	Continued From page 4	F 164	F164	

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to provide personal privacy in the form of a privacy curtain for 1 (R43) out of 29 Stage II sampled residents. Findings include:

R43 resided in a semi private room. Observation of R43's room revealed that there was no privacy curtain during the survey on 5/16/11, 5/18/11 and 5/24/11.

A privacy curtain was installed in R43's room.

An audit of all resident rooms was conducted and privacy curtains are in place for all residents.

The Director of Housekeeping and Laundry will monitor the privacy curtains as a component of weekly housekeeping audits.

Monthly audits, findings and variances will be reported to the Quality Assurance Committee.

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F 164	Continued From page 5 On 5/24/11 in an interview, E5 (Plant Operations Director of Maintenance) confirmed this finding. F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 164	F225 F 225 All reports of alleged abuse, neglect and mistreatment have been reported to the State and the required five day follow up has been sent. All subsequent incident reports have been sent to the State with follow up according to regulation. We have verified that the fax machine is programmed with the correct date. The Nursing staff has received in-service education on incident reporting including the requirement of reporting within 8 hours of the incident. The Director of Nursing or designee will be responsible for ensuring the completion, transmission and 5 day follow-up of incident reports. The Administrator will be given the incident reports daily for review. Any variances will be reported to the Quality Assurance Committee.	7/29/11

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F 225	Continued From page 6	F 225		

incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on review of facility documentation, record review, interview and review of facility policy, it was determined that the facility failed to ensure that alleged violations involving alleged abuse were immediately reported for one (R53) out of three sampled residents, for two incidents during her stay at the facility. The facility also failed to provide the five day follow-up in a timely manner as required by regulations. Findings include:

A facility policy entitled "Policy Reporting of Resident Abuse, Neglect, Mistreatment...and Injury of Unknown Origin" under " Reporting Incidents ...Reporting abuse, neglect, mistreatment " , dated 6/3/08, stated, "...1. Any evidence of abuse neglect, mistreatment shall be reported by any Employee of the facility ....immediately to the supervisor on duty ....4. An incident report shall be completed by the supervisor /charge nurse immediately after the incident is reported. 5. The DLTCRP shall be notified via fax immediately, utilizing the Division of Long Term Care Resident Protection Incident Report form...".

a. Review of R53's alleged abuse incident report, dated 8/23/10 and the investigation documentation indicated that E37 (Nurse) was aware of the incident on 8/16/10 yet the staff did not report it to the management staff or the State until 8/23/10. On 5/24/11 in an interview, E2

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F 225	Continued From page 7 (Director of Nursing) stated that she reported the incident of alleged abuse to the State immediately as soon as she learned about it on 8/23/10. E2 stated that E37 was terminated as a result of not reporting the incident in a timely manner to the State or facility management. Review of the facility investigation documentation revealed that the five day follow up was submitted to the state on 1/17/11. Review of DLTCRP agency 24-hr reporting database revealed that the facility failed to complete a follow up. b. Review of a facility investigation for R53 into another alleged incident of abuse revealed the facility failed to report the incident immediately to the State agency. Facility documentation review and the DLTCRP State database indicated that the incident occurred on 3/10/11, but was not initially reported to the State agency until 3/13/11 and that the five day follow was not completed until 3/17/11. The facility failed to immediately report two allegations of abuse and failed to complete the 5 day follow up as required for R53. On 5/26/11 in an interview, E2 confirmed this finding.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 8	F 246	F246 The call bells were placed and remain within reach for R25, R8 and R71. An audit of call bells was conducted and all are placed within reach of the resident. The Nurse's Aide staff has received in-service education about the need for correct placement of the call bell. The condition and functionality of call bells will be monitored weekly during Building Maintenance Rounds. A random audit of call bells will be conducted during daily nursing rounds and corrections and disciplinary actions will be taken, as appropriate. Any variances will be reported to the Quality Assurance Committee.	7/29/11

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined that 3 (R8, R25, and R71) out of 29 Stage II sampled residents did not have a call bell placed within reach to call for assistance. Findings include:

1. R25 was observed on 5/16/11 at 1:45 PM lying on her bed which was positioned next to the wall by the window. R25's call bell was observed clipped to the light chain of the overhead light which was located approximately 6 feet away.

R25 was assessed on 5/10/11 as a high risk for falls. R25's Care plan, entitled "...is high risk for falls related to dementia", dated 12/21/10, included the approach, "...be sure call light is within reach and encourage to use it for assistance as needed..."

E9 (CNA/Certified Nurse Aide) confirmed that the call bell was out of reach and attached it to R25's bed which when fully stretched, barely clipped the edge of her blanket. The call bell cord was too short.

On 5/16/11 at 2:05 PM, the E2 (Director of Nurses/DON) replaced R25's call bell with one that had a longer cord, acknowledging that it was too short.

2. R8 was observed on 5/25/11 at 7:30 AM lying on her bed which was positioned next to the wall. R8's call bell was observed on the floor under the

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F 246	Continued From page 9 bed and the call bell was out of reach. An interview with E12 (CNA) on 5/25/11 revealed that R8 needed help to get out of bed and that her call bell should be by her side and within reach. E12 stated that R8's call bell was missing the clip to attach it to the bed. 3. R71 was observed on 5/25/11 at 7:25 AM lying on her bed which was positioned against the wall with her call bell on the floor and out of reach. E5 (Plant Operations/Maintenance Director) stated that the clip was missing and proceeded out of the room to get a new clip. An interview with E13 (LPN) on 5/25/11 revealed that R71 was not able to sit on the bed by herself and needed assistance to get up. E13 confirmed that R71 needed to have her call bell by her side.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 9 out of 29 Stage II residents. An environmental tour was conducted with E5, (Plant Operations Director of Maintenance) and/or E6, (Maintenance staff) that revealed housekeeping and maintenance deficiencies. Findings include: 1. On 5/16/11 at 1:58 PM, an observation revealed that R46's room lacked a chair. There	F 253		

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F 253	Continued From page 10 was only a bed, a free standing closet and a night stand present. 2. On 5/16/11 at 3:03 PM, an observation revealed that R24's room lacked a chair. There was only a bed, a free standing closet and a night stand present. 3. On 5/17/11, an observation of R42's room revealed gouges in the floor and dirt around the edges of the bedroom and bathroom floors. On 5/17/11 at 8:50 AM, E5 confirmed the gouges in the floor and at 9:10 AM, E2 (DON) and E24 (Director of Housekeeping and Laundry) confirmed the dirty floors. 4. On 5/17/11, an observation was made of R24 and R46's room revealed cracked/loose flooring that was curled up in the entry way of the room, a potential tripping hazard. On 5/17/11 2:27 PM, E5 confirmed the findings. 5. On 5/17/11, an observation of R21's room revealed gouges in the floor and dirty bedroom and bathroom floors. There was an old french fry on the floor next to the dresser and a band aid on the floor by the sink. The room door would not stay in the open position. On 5/17/11, at 12:20 PM, findings were confirmed by E4 (RN Nurse Supervisor). 6. On 5/17/11 at 2:40 PM, an observation of R47's room revealed gouges in the flooring. 7. On 5/17/11 at 10:00 AM, an observation R59's room revealed dirt and dust on the floor. At 10:07 AM, E4 came to the resident's room and confirmed the findings.	F 253	F253 7/29/11 R46 and R24 were given chairs. All rooms have been cleaned and dirt, dust and debris have been removed. The flooring in all resident rooms identified has been either repaired or scheduled for replacement. The stain on the chair in R43's room has been cleaned. The walls have been repaired. The hoyer lift has been cleaned. The filter has been replaced. All baseboards have been dusted. The wall heater cover has been repaired. The call bell in room 205 has been replaced. The third floor dining room floor has been cleaned. Windows were fitted with screens. All privacy curtains have been inspected and laundered as indicated. Stained ceiling tiles were replaced and broken/missing floor tiles replaced. The commode has been removed from the hoyer lift in the shower room. The resident door has been repaired. The carpeting on the porch has been removed. The elevator was cleaned.	

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F 253	Continued From page 11 8. On 5/16/11 2:34 PM and 5/18/11 at 11:50 AM, an observation of R43's room revealed that there was a low chair next to the bedside nightstand which had a yellow stain on the seat. 9. On 5/17/11 at 2:02 PM, an observation of R36's and R40's room revealed cracked/loose flooring that was curled up in the entry way of the room, a potential tripping hazard. Also, there were gouges in the flooring in front of the chairs. On 5/17/11 at 2:16 PM, findings were confirmed by E2. Observations made during the environmental tour on 5/25/11 beginning at 7:00 AM with E6 (Maintenance staff) revealed the following: 10. Observations were made of clumps of dust behind the doors and/or dirt and debris under the beds in rooms 208, 211A, 207, 205, 203. Additionally, there were dusty baseboards and bed frames in resident rooms observed throughout the facility including room 203; 11. Observations were made at 7:30 AM of unpainted plaster or walls in disrepair in the resident rooms or bathrooms 210, 211, 207A, outside room 203, and the first floor common shower room; 12. An observation was made of dirt on the hoyer lift foot platform located outside room 210; 13. An observation was made of a dusty filter on the oxygen concentrator for R61. The resident was using the concentrator and voiced concern for the liquid in the concentrator was too low.	F 253	F253 continued All resident rooms have been inspected and any environmental or maintenance concerns have been addressed. The Maintenance Director and the Director of Housekeeping and Laundry will conduct weekly resident room and building audits to identify any issues utilizing a standardized audit tool. The audits will be reviewed weekly by the Administrator or designee and variances will be reported to the QA Committee.	

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Interview with E21 (RN, Nurse Supervisor) on 5/25/11 at 8:15 AM revealed that the mouth piece was also uncovered and it was supposed to have a bag on it. She also confirmed the filter was dirty;

14. An observation was made of the wall heater elements exposed and the covers were missing for part of the unit in resident room 205. An interview with E9 (CNA) on 5/25/11 at 2:53 PM revealed that despite the maintenance staff attempting to fix the covers for the wall heater it continued to be loose. She said she had brought up this issue of the wall heater cover issue to maintenance before;

15. An observation was made at 8:35 AM of an emergency call bell cord attached to the wall inside resident room 205 was in disrepair. A small piece of the wire was exposed and the call bell was located outside the bathroom of two residents in that room. An interview with E6 (Maintenance staff) revealed that the cord was not used by the current residents in room 205 but had been used by a previous resident who had a couch located adjacent to that cord. In an interview with E23 (CNA), she stated that the broken cord could not be removed as it caused the call bell to continuously ring. E23 communicated the problem to E6 and the surveyor and advised the surveyor not to touch the broken call bell with the wire area exposed. E6 stated this was a low voltage electrical wire and you could receive a shock from it;

16. An observation was made of a sticky floor in the third floor dining room. No screens were observed on windows in this room;

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17. Observations were made at 7:30 AM, of a stained privacy curtain in resident room 106, and a curtain in disrepair in room 306;

18. Observations were made of a ceiling tile stained in the hallway outside room 213, two loose ceramic tiles on the floor under the sink of the first floor bathroom and one on the wall were in disrepair and uncleanable;

19. An observation was made at 7 AM, of a commode that was observed on top of the hoyer lift by the tub area on the first floor common shower room;

20. Observations of resident room doors on the second floor revealed the doors had a potential for splinters. Interview with E5 (Plant Operations/Maintenance Director) on 5/25/11 confirmed this finding;

21. Observations were made of the third floor screened porch on 5/16/11 to 5/26/11 that revealed a green/black section on the carpeting which appeared to be mold. The elevator carpeted walls were observed dirty.

F 323 SS=E — 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

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F 323	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that resident's environment remained free from accident hazards as was possible as evidenced by unlocked storage closet supply rooms and cleaning carts. Findings include: Observations of the first floor supply storage closet throughout the survey and with E5 (Plant Operations/Maintenance Director) on 5/25/11 at 7:00 AM revealed medical supplies such as irrigation syringes, soaps, disinfectants and other personal supplies unlocked and accessible to residents. Interview with E5 on 5/25/11 confirmed the finding.	F 323	F323 The first floor supply storage closet has been locked. The other storage areas were checked to ensure that they were locked. The Maintenance Director will verify that all storage closets are locked during weekly Maintenance audits, utilizing a standardized audit tool. Any variances will be reported to the QA Committee.	7/29/11
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other documentation as indicated, it	F 325		

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F 325	Continued From page 15 was determined that the facility failed to ensure that acceptable parameters of weight were maintained for one (R67) out of 29 sampled residents. R67 experienced a severe weight loss of 20 lbs. (14.6%, although incorrectly recorded by the facility as 17%) in one month after being admitted to the facility. A nutritional supplement was ordered by the MD on 1/17/11 when R67 lost 5 lbs., however, there was no evidence that the facility monitored the weights and reassessed the effectiveness of their intervention until 2/10/11 when R67 lost another 15 lbs. and E14 (registered dietitian) was notified. On 2/10/11, E14 ordered the nutritional supplement to be increased, ice cream to be given between meals and R67's diet was changed to pureed. There were no assessments or interventions implemented by E14 from the initial evaluation done on 1/5/11 in which R67's weight was stable until 2/10/11 after R67 lost 20 lbs. The facility additionally failed to follow their policy regarding notification of the MD and dietician of weight loss of 5 lbs. or greater. R67's weight declined from 129.5 lbs. to 115 lbs. on 2/4/11 in approximately one week, yet E14 and the MD were not notified until 2/10/11. In the interim, R67 was being evaluated for mental status changes by the MD and R67's weight loss was not being addressed. R67 was hospitalized on 2/11/11 for mental status changes. Findings include: The facility policy (undated) entitled "Weekly Weights" stated, "Objective: To assure... resident's weight is assessed accurately and in a timely manner each week. Policy: 1) All new admissions... weighed every week for four weeks to obtain a baseline. 2) Any resident with a gain or loss of 5 lbs will be placed on weekly weights	F 325	F325 R67 is now weighed weekly and is receiving prescribed supplements consisting of 4 ounces of MedPass three times a day. She has been consuming 100% of the supplement with the exception of 5 times in June when she consumed 50%. There has been no further weight loss. Her current weight is 122.5 lbs. She was weighed on June 1 and her weight was 119.5 lbs. Weight on 6/8 was 120.5 lbs. and on 6/15 her weight was 121 lbs. Resident's appetite is between 50% and 100% for breakfast as well as for lunch. She consumes 25% to 100% for dinner. A bedtime snack is offered and she usually refuses. Resident care plan has been amended to include potential for weight loss. R67's food intake percentage is measured and documented. The dietician has reviewed all resident weekly weights and no other resident was found to be at risk.	7/29/11

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F 325	Continued From page 16 for four weeks. 3) If weight is a gain or loss greater than 5 lbs the nurse must verify the weight 4) Dietitian will be notified. 5) The physician will be notified. . 6) make sure weight is documented on the chart." R67 was admitted to the facility on 12/30/10 with diagnoses including Alzheimer's dementia and hypernatremia (high sodium levels). Her admission weight on 12/30/10 was 136.5 lbs. Review of R67's admission MDS assessment, dated 1/10/11, listed R67 as severely cognitively impaired and she required set-up help by staff for eating with oversight, encouragement or cueing. R67 was observed in the dining room feeding herself lunch on 5/23/11. Weights for R67 were found in multiple places- on the monthly weight record, weekly weight records (usually only indicated as week #1, #2, etc. for specific month), and on the Medication administration record (MAR). Re-weights were not consistently dated. Weights were as follows: 12/30/10 (admission)- 136.5 lbs. 1/4/11- 136.5 lbs. 1/13/11- 131.5 lbs. (5 lb. loss) 1/20/11- 128.5 lbs. (8 lb. loss) week #3 Jan.- 125 lbs. (11.5 lb. loss) week #4 Jan.- 129.5 lbs. 2/4/11- 115 lbs. (21.5 lb. loss) 2/7/11- 115 lbs. with re-weight of 116.5 lbs. (20 lb. oss) 2/11/11- to hospital R67's weight was 136.5 lbs. on 1/4/11 and 116.5 lbs. for a re-weight done on 2/7/11, reflecting a	F 325	All residents are weighed monthly and the first weight of the month is considered the first weekly weight for those on weekly weights. Weights are recorded in the resident chart on the weight form. Weekly weights are done on Wednesdays and are reported to the physician and the dietician on Thursdays. The Director of Nursing or Assistant Director of Nursing communicates weights to the physician and immediately reports any significant changes. The Nursing staff received education on resident weights, recording and reporting. The Director of Nursing or designee will monitor weights weekly and communication to the dietician and physician. Any variances will be reported to the QA Committee.	

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severe weight loss of 20 lbs. (14.6%) in one month.

Monthly weight record instructions included "... Identify weight gain or loss in the appropriate WT. CHANGE column by specifying the difference (in pounds) between "new" weight and previous weight. The DATE NOTIFIED columns need only be completed when it is necessary to notify the individuals listed (family, doctor and dietary). Refer to the bottom of this form for undesired weight loss parameters. Each entry must be signed by a nurse...". There was no information recorded in the WT CHANGE and DATE NOTIFIED columns indicating that the facility failed to monitor R67's weight loss.

Review of the medication administration record (MAR) for % Med Pass (nutritional supplement) consumed from 12/30/10 to 2/10/11 varied from 0-100%. R67 drank 100% more often during the day than in the evening.

Review of the MAR for % of meal consumption from 12/30/10 to 1/15/11 revealed variable intakes from 0-100% with an average of about 50% and from 1/16/11 to 2/10/11 0-75% with an average of about 25%.

A care plan was developed on 1/5/11 for variable oral intakes and history of hydration issues. Interventions included, "monitor weights".

On 1/17/11 a care plan was developed for weight loss for R67. The goal listed was to maintain weights weekly for 2 months. Interventions included monitoring and recording of weekly weights and report to MD as needed. The care

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plan was not revised until 2/21/11 when R67 returned from the hospital.

A physician's progress note, dated 1/17/11, stated that R67 was seen for back pain and it was noted that R67 had a 5 lb. weight loss. The MD ordered a Med pass (nutritional supplement) 4 ounces 2 times a day.

On 2/1/11, a physician's progress note, stated that R67 was seen for recent falls and "... wt loss: cont Med pass, follow prealbumin (test used to detect and diagnose protein-calorie malnutrition)...". A prealbumin was not ordered, however.

On 2/4/11, a physician's progress note, stated that R67 was seen for lethargy (fatigue) and her Zyprexa (antipsychotic) was discontinued and urine studies were ordered.

On 2/8/11, a physician's progress note, stated that R67 was seen due to continued lethargy despite the discontinuation of Zyprexa. Multiple laboratory tests (did not include prealbumin) were ordered as well as a CT scan of the head.

There was no mention of R67's continued significant weight loss in the progress notes on 2/4/11 or 2/8/11.

A nurse's note, dated 2/10/11, stated, "The pt.'s wt. in Jan. 2011 was 136. 5 lbs. and wt. in Feb. 2011 was 116.5 lbs. The pt. lost 20 lbs (14.6%) in one month. MD, RD (registered dietician) and family made aware." Although R67's weight was identified at 115 lbs. on 2/4/11, the MD, RD, and family were not notified until 6 days later, despite

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ongoing evaluation by the MD during this time. R67 experienced a severe weight loss of 14.6% in one month.

E14 (dietician) was in to evaluate R67 on 2/10/11 and after consultation with an MD, she wrote orders to increase the Med Pass to 3 times a day, ice cream with all meals and document % consumed on MAR, offer 4 oz. water 3 times a day between meals with % on MAR, and change R67's diet to pureed. Despite R67's continued weight loss (additional 15 lbs.) after the initial loss of 5 lbs. in which an MD ordered Med pass 2 times a day on 1/17/11, there were no other interventions ordered in an attempt to improve R67's to ensure acceptable parameters of weight.

Review of R67's initial Nutrition Risk Assessment (completed by E14- registered dietician), dated 1/5/11, stated that R67's daughter stated that the resident was "not a big eater". R67's weights were stable at 136 lbs. and R67 was assessed as no/low risk for weight loss. R67's weight on 1/4/11 was 136.5 lbs., the same as it was on admission. Review of E14's dietary notes revealed that the facility failed to ensure that E14 monitored, evaluated and implemented appropriate interventions for R67's weight loss until she was notified by nursing of R67's 20 lb. weight loss on 2/10/11. There was no documentation by E14 from 1/5/11 until 2/10/11.

A physician's progress note, dated 2/11/11, stated, "Seen & examined secondary to abn labs. Pt. has decreased po (oral) intake last week or two & increased lethargy... also had 20 lb weight loss in last mth... wt was 129.5 last week in Jan & on 2/7 weight is 115 lbs... Problem List: 1)

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hypernatremia (sodium was 156 on 2/9/11, was 147 on 1/4/11; normal is 135-145) 2) lethargy/change in ms (mental status) 3) wt loss...". R67 was sent to the ER for evaluation of hypernatremia and lethargy on 2/11/11 and she was hospitalized until 2/21/11. R67 was additionally diagnosed with questionable normal pressure hydrocephalus (increased intracranial pressure due to accumulation of cerebrospinal fluid) while in the hospital.

On 5/24/11, E25 (LPN) was interviewed. E25 stated that when weight loss occurs, Med pass is started, the family and MD are to be notified of any weight changes, and weekly weights are to be done on bath days (Monday and Thursday for R67).

E26 (charge nurse) was interviewed on 5/25/11. E26 confirmed findings and stated that R67 was not a hospice resident.

E14 (dietitian) was interviewed on 5/25/11 via telephone. E14 confirmed that she could see why we (DLTCRP) had concerns by what was in the record. She stated that R67's daughter and she "talked all the time" and "could not figure out what was going on." E14 stated that she should have written down her conversations with R67's daughter. When asked how she monitored weights, E14 stated that when in the facility 2 times a week she first checks for new admissions, who went out to the hospital, and anyone with skin issues. After that, she stated that she walked around observing residents eating a meal and she talked to them. If she noticed something, E14 stated she would then go to the nurse and ask if there were any changes

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F 325	Continued From page 21 and she also talked to families. Despite these practices, the facility failed to ensure that R67's weight was monitored resulting in a severe weight loss of 14.6% in one month.	F 325	F371	7/29/11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observation and interview, it was determined that the facility failed to prepare, distribute and serve food to the residents under sanitary conditions during dining observations of the 2nd and 3rd floor dining rooms on 5/16/11 and 5/23/11. Findings include: 1. Observation of the second floor steam table during breakfast on 5/16/11 at 8:05 AM revealed the temperature of the puree eggs to be at 90 degrees Fahrenheit (F) and the sausages to be at 80 F while they were being served to the residents. The surveyor touched the external surfaces of the steam table and it was cold. The surveyor requested the food not be served when these holding temperatures were observed. The food temperature was not recorded in the	F 371	The food holding warmers are turned on to their highest level one hour prior to the food being delivered from the kitchen. The food temperature is checked when it leaves the kitchen and checked again in the warmer and prior to plating for service to the resident. The pans are marked for correct water levels to maintain temperature. Water levels are recorded in the temperature logs. Pan covers for the steam table have been ordered. Food is served immediately upon arrival in the dining area. The correct Applicant Food Employee Health Form has been obtained and is provided to all food service applicants. Existing food service employees have received and completed the correct form and they are maintained in their personnel files. Dietary staff will complete the form annually. The food temperatures were checked on the other floors and found to be served at 165 degrees. Food	

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F 371	Continued From page 22 facility temperature log. On 5/16/11 in an interview, E15 (Dietary staff) stated that she would take the food to the kitchen for E16 (Cook) to reheat the food to the proper temperature even though there was a microwave in the dining room. E15 stated that she had tested the temperatures of the food downstairs in the kitchen and the temperatures were fine at the time. On 5/16/11, an interview with E16 revealed that the staff was supposed to determine the temperature of the food when it was placed in the steam table. On 5/16/11 at 8:30 AM, an observation of E16 revealed that he warmed the food to 145 F. The Surveyor then prompted E16 to heat the food to 165 F for 15 seconds before it was served to residents. E18 (Food Service Director) was not present in the facility at this time. 2. Observations of the third floor steam table during breakfast on 5/16/11 at 8:20 AM revealed the scrambled eggs were 90 F. On 5/16/11, E17 (CNA) confirmed this finding. All residents had their meals at that time. E17 stated she could reheat food to 165 F in the microwave if steam table temperatures were low. On 5/16/11, E17 also stated that she did not test the temperatures of the food in the steam table but kitchen staff did. On 5/16/11 at 8:30AM, E16 heated up the egg to 145 F until the surveyor stated it need to be heated to 165F. When the surveyor asked why E15 did not heat the food to the proper temperature in the microwave on the 2nd or 3rd floor, E16 stated that he did not know as he was not a supervisor.	F 371	temperature logs were checked and are maintained on each floor. The Dietary staff has received in-servicing on food temperatures. The entire staff was in-serviced on hand washing and glove use. The Dietary Manager will audit the food temperatures on a weekly basis to ensure correct temperature maintenance and accurate recording of temperatures. The Staff Educator will supervise and monitor weekly the correct use of gloves during food service and hand washing. The Business Office Manager will ensure that Dietary applicants complete the required form. Any variances will be reported to the QA Committee.	

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	08A020	A. BUILDING _____ B. WING _____	C 05/26/2011

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F 371	Continued From page 23	F 371		

On 5/17/11, an interview with E18 (Food Service Director) revealed that she was at work on 5/16/11 at 9:00 AM. She stated she came in after everything had happened.

3. Observation of the third floor steam table on 5/23/11 during lunch revealed the beef stroganoff with a temperature of 115 F. E19 (Dietary staff) confirmed this finding and stated that she tested the steam table food a while ago when she first received it from the kitchen and the food temperatures were fine. The surveyor tested the surface of the steam table and noted it was cool and not hot. Surveyor requested the pans be moved so that the surveyor could observe the water in the steam table and the water was not touching the food pan. The water in the steam table used for keeping food hot was 153 F. E17 was observed heating food for the residents in order to serve the residents their meals. E17 placed the food in the microwave for 15 seconds. When the food was tested, the food that E17 had reheated had a temperature of 120 F. E19 stated that she usually heated up food in the microwave for at least a minute. When the surveyor asked her if this heated the food up to 165 F for 15 seconds she did not know if this time would heat it up for that long.

4. Review of facility Applicant Food Employee Health Forms revealed an unsigned form for E34, when he was first hired, that alerted facility if the new employee had certain foodborne illness that would prevent them from working with food. Additionally, documentation review of Applicant Food Employee Health Forms revealed that the facility failed to review if the newly hired food

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employees (E34 and E35) had the Norovirus illness which could had prevented employees from working with food served to residents. The food employee health forms had the Norovirus illness missing from the form.

5. On 5/16/11 at 7:40 AM, E17 (CNA) stated that the dietary aide brought up the food and then she, E17, generally served it unless there was an additional dietary staff person available. With gloved hands, E17 was observed picking up 3 to 4 coffee cups at one time by placing her fingers inside the cups, then she opened cabinet doors to remove sugar substitute and put it into the coffee which she then served to R40.

E17 washed her hands, re-gloved, got cereal for R22 and R36 and then went into the refrigerator and got milk in small containers for R36, R22 and R34. On 5/16/11 at 7:50 AM, E17 was observed assisting E12 (CNA) to seat R46 at a dining room table. An observation revealed that E17 touched the arm and back of the chair with her gloved hands. With the same gloves on, E17 then returned to serving toast to R34 and eggs, sausage and toast to R22.

The facility failed to serve food under sanitary conditions. On 5/26/11 at 1:50 PM in an interview with E17 regarding the dining observation of 5/16/11, she confirmed that she touched a variety of surfaces and then served food to residents without removing gloves, washing hands and re-gloving.

4. Review of facility Food Employee health form documentation revealed one (1) of two unsigned form for E34, upon hire (hired 7/19/10). The screening form of Food employee health at time

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F 371	Continued From page 25 of hire, alerted facility if the new employee had certain foodborne illness that would prevent them from working with food. Additionally, review of Food Employee health forms revealed that the facility failed to review if the newly hired food employees (E34 and E35) had the Norovirus illness which would prevent employees from working with food. The food employee health forms did not address if the staff had the Norovirus illness when they were first hired which could have prevented the staff from working with food served to residents. E35 was hired on 9/19/05. E18 confirmed these findings on 5/25/11.	F 371	F372 The dumpster area has been cleared of debris and the lid has been closed. The dry storage area floor was cleaned of debris. There are no other areas on the property or kitchen with open waste or debris.	7/29/11
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations of the dumpster area and staff interviews, it was determined that the facility failed to keep the dumpster, storing garbage and refuse, tightly covered to prevent pest harborage. Additionally, bags of garbage in front of the dumpster and debris around the dumpster were observed on the ground. Findings include: Observations on 5/16/11 at 7:05 AM of the dumpster area outside the kitchen revealed a refuse dumpster with the top lids opened and side door open. Three black bags of garbage were observed in front of the dumpster. Observations of the dumpster area on 5/17/11 at 7:00AM revealed the dumpster lids opened and	F 372	The Dietary and Nursing staff have been in-serviced on placing refuse in the dumpster and closing the lid. The dietary staff was in-serviced on keeping the floor clear of debris. The dumpster area will be monitored by both the Director of Maintenance and by the Interdisciplinary Rounds staff during their daily and weekly audits of the building. The Dietary Manager will monitor the cleanliness of the kitchen floor daily. Any variances will be reported to the Quality Assurance Committee.	

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F 372	Continued From page 26 bags of garbage on the ground around the dumpster area. Cats were roaming around the dumpsters. In an interview with E18 (Food Services Director) on 5/17/11 at approximately 10:00 AM, E18 stated that the dumpster was half empty and she had to place the bags inside the dumpster herself. E18 confirmed this finding. Observations on 5/18/11 at 7:30 AM revealed the refuse dumpster with side door open, refuse bags in dumpster overflowing, and debris around the dumpster on the ground. Cats were observed roaming around the dumpsters. On 5/23/11 at 7AM, 5/25/11 at 6:50 AM, and on 5/26/11 at 6:45 AM, the dumpster side door was observed open and cats were observed roaming around the dumpster area. 2. On 5/16/11, debris was observed on the floor of the dry food storage area under the cereal storage racks in the kitchen.	F 372		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		

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F 431	Continued From page 27 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the narcotic drugs and biologicals that were stored in the medication room were affixed and locked, properly labelled and were not expired. Additionally, it also failed to ensure that the drugs and biologicals that were stored in the third floor medication carts were not expired and were labeled with expiration dates. Findings include: 1. Observation on 5/18/11 at 9:25 AM of the second floor medication storage room with E4 (Charge Nurse) revealed the following: a. The narcotic box (a black plastic container	F 431	F 431 The narcotic box is now permanently affixed and locked. The medication room has been locked. The medications refrigerator has been affixed to the floor and is locked. The house stock that had expired has been removed. The influenza vaccine with conflicting expiration dates has been discarded. The Bisacodyl suppositories were removed. The third floor medications missing expiration dates were discarded and replaced . The contract with the institutional pharmacy which serviced the facility during the time of this survey has been terminated and a new pharmacy provider will begin servicing the facility on June 27, 2011. The Consulting Pharmacist from the newly contracted pharmacy will ensure that all medication is stored properly and locked and secured as required by regulations. Additionally, the new pharmacy will be responsible	7/29/11

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F 431	Continued From page 28 approximately 12" X 14" X 3") was observed not affixed to the wall and stored on the top of the emergency medication box inside the medication storage room. The medication room was observed locked yet the narcotic box was not locked. E4 confirmed this finding. b. Observation on 5/18/11 at 9:30 AM with E4 of the refrigerated medications stored inside the second floor medication storage room refrigerator revealed narcotics such as Lorazepam liquid used for two residents (R8 and R52) were stored in the refrigerator. The refrigerator was observed not affixed and unlocked. c. Observation on 5/18/11 at 9:45 AM in the second floor medication room with E4 revealed six (6) of ten (10) bottles of house stock (12-oz) Mid-Acid Anti-acid liquid that had expired on 3/11 (for two of the bottles) and 4/11 (for four of the bottles). d. Observation on 5/18/11 in the second floor medication room with E4 revealed one (1) container of Fluviring Influenza virus vaccine stored inside the medication refrigerator that had expired on 3/31/11. The label that was affixed to the bottle had an expiration of 12/2/11. E4 confirmed that the label affixed to the bottle was incorrect. Additionally, fifteen (15) Bisa Codyl 10-mg suppositories were observed stored loose on a blue rack inside the refrigerator. The suppositories had no expiration dates and were unlabeled. During an interview on 5/18/11, E4 stated that they may have been house stock, and	F 431	F431 continued for supplying and maintaining drugs, etc. within expiration dates. The Director of Nursing or designee will monitor the locking of medications, refrigerator and medication room and randomly audit medications for expiration dates. Any variances will be reported to the institutional pharmacy and to the QA Committee.	

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F 431	Continued From page 29 she did not know when they expired as the label was missing. E4 stated that the suppositories may have been from the same suppository zipped bag observed stored in the same blue rack. The zipped bag suppositories had an expiration date of 2/27/12 During an interview on 5/18/11 at 10:05 AM, E2 (Director of Nursing) acknowledged the findings. 2. Observation on 5/18/11 at 11:30 AM of the 3rd floor medication cart with E27 (Nurse) revealed there were medications which had expiration dates missing. a. The container of Fish oil for R22 had a refill date of 6/5/11 yet, the expiration or discard dates were missing from the container. The medication container was labeled under expiration "see package". Interview with E27 revealed that the medication did not come with a package with the medication. She stated that the pharmacy did not send a package with the medication. b. A bottle of Oscal 500 for R40 had no expiration date. The bottle indicated "to see package" for expiration date but had no expiration dates. Interview with E27 on 5/18/11 revealed that the bottle indicated the refill date of 6/1/11 as the date they needed to order the medication again. E27 stated that there were two other dates noted on the Oscal 500 bottle of 4/10/11 and 5/6/11 yet, E27 did not know, nor did the bottle state, what those dates were for.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 30 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	F 441 The facility is now tracking trends and analyzing any increase in infection rates. The Infection Control policy has been amended to include scabies and lice infestations. The water temperature has been increased to provide for sanitation of laundry. The water temperature gauges are replaced.The exhaust fan has been repaired and is working. The soiled linen is now bagged and stored within the dirty linen area. The water temperature throughout the building have been checked and found to be within compliance. All vents are working and have been cleaned. The Director of Maintenance and the Director of Housekeeping and Laundry and the laundry staff have received in-service education on water temperatures, exhaust vent maintenance and handling of soiled linen and laundry.	7/29/11

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F 441	Continued From page 31 Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to maintain an infection control program under which it analyzed and investigated any increase in the rate of infection to prevent the development and transmission of disease and infections. Additionally, the facility failed to follow recommended washing of soiled linen regarding water temperatures and ventilation areas storing soiled linens. The facility failed to handle, store, and process linens so as to prevent the spread of infection in regards to nonworking vents and storage of soiled linen. Findings include: The facility's Infection Control Policy and Procedure was reviewed. 1. Review of Monthly Infection Control Logs from July 2010 to May 2011 with E3 (ADON, Infection Control Nurse) on 5/17/11 revealed that the facility monitored the occurrence of infections, however, it failed to trend the organisms to determine if there was a pattern of infection that the facility needed to address and implement corrective actions. The facility failed to analyze and investigate any increase in the rate of infection, and to establish controls to prevent infections in the facility for 7/2010 to 5/2011. Additionally, review of the infection control procedures revealed missing procedures associated with the handling of infections such as scabies and lice. Interview with E3 (ADON) on 5/17/11 confirmed these procedures were not available at the facility. Interview with E3 on 5/17/11 revealed that	F 441	The Laundry area will be audited as a component of weekly Interdisciplinary Rounds. Any variances will be reported to the QA Committee.	

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although the infection line listing collected was discussed at the QA (Quality Assurance) meetings, she confirmed the reporting did not exist.

2. Facility failed to handle, store, and process linens so as to prevent the spread of infection in regards to nonworking vents and storage of soiled linen as follows:

a. Observations on 5/24/11 at 3:05 PM of the laundry's two washer's water temperatures revealed the temperature to be below 100 degrees Fahrenheit. The hot water storage tank temperature had no gauges indicating what the temperature to the washers were. Interview with E5 (Plant Operations/Maintenance Director) on 5/25/11 at 2:30 PM revealed that the temperature of the washer water was 166 degrees Fahrenheit when he disconnected the hose behind the washer to test the temperatures. The facility failed to monitor the hot water temperatures for the washing of soiled linen and failed to established controls to prevent infections in the facility.

b. Observations of the laundry room on 5/24/11 at 2:45 PM with E5 (Plant Operations/ Maintenance Director) revealed that the exhaust vent connected to the wall/window and the ceiling inside the soiled washer room was not working.

Interview with E5 on 5/24/11 confirmed this finding. Interview with E6 (Maintenance staff) on 5/25/11 revealed that he checked the exhaust vents for dirty filters in the common areas of the facility and resident rooms but did not check the vents for exhausting air out of the rooms.

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F 441	Continued From page 33 c. Observations made throughout the survey of the third floor hallway area revealed two carts: one cart stored soiled personal resident linen and the other cart stored soiled bed linen. The soiled linen was stored in the hallway where the exhaust grill was connected to the third floor air conditioner intake. The exhaust vent was not exhausting to the outside per regulation requirements and supplied soiled linen air to a system which was supposed to supply fresh air to the residents. Interview with E5 on 5/24/11 revealed that the air conditioner supplied cool air to all resident rooms, dining room, activity area, and all other rooms on the third floor, and not the whole facility. E5 stated that he was not aware if the hallway was under negative pressure as required per regulations for stored soiled linen. Interview with E22 (Staff Development Nurse) on 5/25/11 revealed that the soiled linens have always been stored on the third floor hallway the same way. On 5/26/11 at 7:00 AM, the two carts were observed stored in the same location full of soiled linen. Upon opening the carts, the soiled linen were observed loose inside the cart and not bagged. c. Observations of the laundry room washer area on 5/26/11 at 8:00 AM revealed two bags of soiled linen on the floor.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive	F 463		

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F 463	Continued From page 34 resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that they were equipped to receive resident calls through a communication system for all residents from the resident rooms and bathrooms for three (R40, R52, R59) out of 29 stage II sampled residents. Additionally, the bathroom emergency call light in room 207 was non functional. The facility also failed to ensure that there was a monitoring system in place for checking the function of all the call bells in the facility on a regular basis. Findings include: 1. On 5/17/11 2:07 PM, an observation of the room where a husband and wife reside, R40 and R36, revealed there was only 1 call light to share between the 2 beds. The call bell was draped across R36's bed and attached to R40's bed. The cord was hanging between the beds approximately 6 to 8 inches off the floor, a potential tripping hazard. On 5/17/11, R36 stated that both she and her husband were able to use the call light. Review of the Minimum Data Set Assessment, dated 3/28/11, revealed that R36 was coded as alert and oriented with a BIMS (Brief Interview for Mental Status) score of 10. Also, R36 demonstrated it by activating the call bell in the surveyor's presence. The facility failed to have a call light for each	F 463	F 463 R36, R40, R52 and R59 now have functioning call bells placed within reach and available in bathrooms. The bathroom call bell for R11, R35 and R51 is now functioning. The call bell for R40 and R36 was replaced with a call bell that provides a call bell to each individual. An audit of all call bells revealed no other problems. The Nurses aide staff was in-serviced on reporting of call bell malfunction and on the correct placement of call bells in a resident room. The Director of Maintenance will monitor call bell functionality as a component of Maintenance audits. Weekly Interdisciplinary Rounds will also track call bell function and placement. Any variances will be reported to the QA Committee.	7/29/11

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F 463	Continued From page 35	F 463		

resident, R36 and R40, at the bedside in their room. On 5/17/11 at 2:18 PM, findings were confirmed by E2 (DON).
2. Observations on 5/16/11 at 1:35 PM revealed that call bells in the bathrooms for rooms 211 and 213 used by R52 and R59 were non-functional. This was confirmed by E4 (charge nurse) and she stated that she would notify maintenance.

E10 (CNA) was interviewed on 5/17/11 at 2:05PM and she confirmed that R52 and R59 were both physically capable of using these bathrooms.

On 5/24/11 at 3 PM, observation revealed that the call bells in the bathrooms for R52 and R59 were working properly.

E11 (RN) stated during an interview on 5/25/11 at 2 PM, "We check them when we go into the room. If an aide says that a call bell is not working, they report it to the nurse who then reports it to maintenance".

On 5/25/11 at 2:10 PM an interview with E2 (Director of Nursing) and E1 (Administrator) confirmed that the facility does not have a system in place for monitoring proper functioning of call bells. E1 stated, "They are ringing all the time, so we assume that they are working".
3. Observations on 5/25/11 at 8:30 AM with E6 (Maintenance staff) revealed that the emergency call bell in the bathroom used by three residents in room 207 (R11, R35, R51) was nonfunctional. E6 was observed pulling the bathroom call light cord on 5/25/11 and it did not trigger a light or a sound, at the nursing station panel to alert staff that residents needed help. E6 confirmed the finding

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F 466 SS=F	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and staff interview, the facility failed to have a procedure that addressed emergency water procedures for non potable water emergencies. Findings include: On 5/25/11 at 10:40 AM, review of the emergency water procedure revealed that there was no water procedure for non potable water in the event of a water emergency. The procedure review and dietary kitchen invoices revealed that in case of a water emergency, the facility did have a supply of drinking water yet this was not located in their emergency water procedures. A revised copy of the potable water procedure was provided on 5/26/11. An interview with E18 (Food Service Director) on 5/25/11 at 12:45 PM revealed that there was an emergency water procedure that addressed the potable water that was found in a dietary manual managed by dietary. The book was not accessible to everyone and they did not use that for training. She stated that they keep 33 cases of 5 gallon containers each for all residents in case of emergency yet that is not documented anywhere. She stated that their vendor would bring non potable water if they asked but they had	F 466	F 466 The facility has obtained plastic, collapsible containers (water buffalos) for storing non-potable water in the event of an emergency. The facility's Disaster Plan is amended to include provisions for non-potable water including immediately filling the bathtubs and water buffalos. We have a contract with US Foods to provide water, as needed. The facility's Disaster Plan is being revised to include provisions for any type of emergency situation. The entire staff will receive in-servicing on the revised Disaster Plan and be part of orientation for new employees. The Staff Educator or designee will ensure proper training and availability of non-potable water and any variances will be reported to the QA Committee.	

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F 466	Continued From page 37 no information on this. E18 confirmed that the facility had no water emergency procedures for non potable water. An interview with E2 (DON) on 5/26/11 confirmed that the facility did not have a procedure for the non potable water.	F 466	F 467 All exhaust fans identified as non-functional have been repaired. An audit of the exhaust fans has been conducted and all are functioning properly. The Maintenance Director has been educated on the monitoring and need to immediate repair of exhaust vents. Weekly Interdisciplinary Rounds will include checking the functionality of exhaust vents. Any variances will be reported for repair and to the QA Committee.	7/29/11
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain exhaust vents in common areas such as one common shower on the third floor, resident's bathrooms, hallways and janitor closets in working condition. Additionally, the facility failed to have a system in place to check the functionality of the vents on an ongoing basis. Findings include: 1. Observations on 5/16/11 at 11:00 AM of resident bathrooms 101/103, 102, 104/106, and 105/107, 108/110 revealed the exhaust vents were not working or exhausting air out of the room. Interview with E5 (Plant Operations/Maintenance Director) on 5/16/11 and 5/17/11 revealed that the belts in the motors were in disrepair. 2. Observations on 5/25/11 at 8:00 AM revealed	F 467		

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F 467	Continued From page 38 the exhaust vent in the resident bathroom was not working and there was an odor in the resident room 207. 3. Observations on 5/25/11 at 7:00 AM with E5 revealed the exhaust vents on the wall and the ceiling were not working in the third floor common shower/tub room The shower room had a urine smell at the time. E5 confirmed the exhaust vents were not working. 4. An observation on 5/25/11 at 8:35 AM of the janitor closet exhaust vent in the 2nd floor by the dining room with E6 (Maintenance staff) revealed that it was not working. The vent was not exhausting the air in the room where bio hazardous materials were stored. 5. An observation on 5/16/11 at 7:55 AM of the exhaust vent in the janitor closet in the kitchen revealed that it was not working. An interview with a facility ventilation contract mechanic and with E22 (Training Coordinator/ Social Service) on 5/25/11 at 2:47 PM revealed that the mechanic was in the process of repairing the exhaust vent motors He was observed carrying motors which he stated were the motors from the shower room and the laundry. He stated, "It was a good thing you guys came and brought these things up" On 5/25/11 in an interview, E6 stated that they checked vent filters but that they did not have a system to check that the vents were functional.	F 467		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency	F 518		

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F 518	Continued From page 39 procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to train and have all employees competent in fire emergency procedures. Additionally, the facility failed to train staff upon hire in all emergency procedures for six (6) out of six (6) recently hired staff (E7, E29, E30, E31, E32, E33) reviewed. The facility failed to conduct fire drills quarterly on all shifts in the past year. On 5/23/11 at approximately 12:54 PM, a fire drill was conducted by the facility with the Fire Marshall present. Findings included: 1. On 5/23/11 a fire alarm was activated at 12:54 PM by E1 (administrator) after she discovered a red flashing light (signifying a fire) in the doorway of room 110. Observations on the first floor during the fire alarm revealed that staff were observed not checking doors with the backs of their hands prior to entering rooms and not all staff were aware of the new magnet system implemented by the facility. E20 (business office manager) was observed closing a resident door after checking the resident room from the doorway and E1 informed her to place the magnet on the outside of the door. After E1 left, E20 was heard asking where the magnets come from. At 12:58 PM, a CNA was observed pushing R58 (room is next to where the simulated fire was) through the fire zone, instead of into the stairway	F 518	F 518 7/29/11 The entire staff have been re-trained on fire emergency procedures. A magnet system is in place to identify resident evacuation status. Red dots are moved from inside the door frame when a resident is in the room and would need to be evacuated. Green dots indicate that the room is clear and there are no residents in the room. The facility's Disaster Plan is being revised to include all types of emergencies. The entire staff has received multiple in-services on fire emergencies. The facility has conducted fire drills for all shifts. Drills were conducted on 5/31, 6/1, 6/2, 6/6, 6/7, 6/8, and 6/9. All staff will be in-serviced on the revised Disaster Plan on hire and at least annually. The Staff Educator or designee will ensure that all staff has received training on fire emergencies and the	

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F 518	Continued From page 40 near R58's room. At 1 PM, an all clear was called. The facility never moved R23 who was only a few doors away from the fire. R23 was asleep in her bed the whole time. When E24 (head of housekeeping) was asked what the green magnets were for, she stated that it meant there was no fire in the room. Staff were observed not completely going into resident rooms to look for fire or checking resident bathrooms. 2. On the second floor, staff were shutting doors to residents' rooms. E21 (nurse supervisor) was unable to locate the magnet for room 208 and shut the door without placing the magnet, when another staff member stated that every room had a magnet on the inside of the door. E21 then located and placed the magnet on the outside of the door appropriately. No staff were observed checking the resident doors for signs of fire before opening them, such as using the back of their hand to detect heat, etc. Subsequently, doors to rooms 208, 210 and 212 were initially opened to detect if there was a fire present in the residents' room, then reopened to account for residents on the census sheet. These doors did not fully shut after being reopened. During an interview on 5/23/11, E22 (Social Worker) acknowledged that the doors had not fully shut and immediately shut the doors completely. E22 had to repeatedly pull the doors in order to close them completely. During the fire drill, R65 came back out of her room, leaving her door open and sat on a chair at	F 518	Disaster Plan. Fire drills were conducted weekly for each shift as outlined in our Plan of Correction dated 5/24/11. We will conduct drills once a month for each shift. Any variances will be reported to the QA Committee.	

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F 518	Continued From page 41	F 518		

the end of the hall next to the windows. Initially, she sat there unnoticed by staff. After a few minutes, E7 (CNA) had to alert other staff that R65 needed to be put back in her room. R65 was then escorted back to her room and the door was closed. Twenty (20) other residents remained in the dining room with staff.

Additionally, when the fire alarm sounded, the announcement of the location was unclear to the surveyor on the second floor.

During an interview on 5/23/11 at 3:50 PM, findings were discussed with E1 (Administrator), E2 (Director of Nursing), E3 (Assistant Director of Nursing), E5 (Maintenance Director) and E22 (Social Worker). When asked what the use of magnets signified, E2 and E22 stated that it was to indicate whether a fire was present in that room. The facility failed to have a system in place to denote which rooms had been evacuated of residents. E1 stated that the facility would immediately develop a system using the magnets to indicate the evacuation status of residents in their rooms and that all staff would receive additional inservices.

3. When the code red was announced, the location was unable to be heard by 2 surveyors who were on the 3rd floor in the hallway adjacent to the lounge/living room.

At 12:58 PM, while the fire alarm was still sounding, R43, a severely cognitively impaired resident, was observed opening her room door and without closing it, ambulated to the living room. R43 then sat down in an arm chair in the living room. There was no staff present with this

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F 518	Continued From page 42 resident. At 12:59 PM, E3 (ADON) opened her office door and came out of her office on the 3rd floor. She turned right and opened the fire door and walked into the hallway. E3 did not acknowledge that R43 was seated in the lounge/living room or redirect or assist R43. At 1:00 PM, the fire drill concluded and the all clear was announced. On 5/23/11 at 3:53 PM, the Administrative staff was informed of the findings. 4. Review of the fire drills from May 2010 to May 2011 revealed that the facility failed to conduct fire drills quarterly for second shift. Fire drills conducted on the 2nd shift during the 3rd quarter of 2010 and the 1st quarter of 2011 were missing. Staff were not trained in fire drills during these two quarters, or six months. 5. Review of the new hire orientation checklist revealed that six (6) out of six (6) staff (E7, E29, E30, E31, E32, E33) had attended new hire orientation. However, the checklist only included "fire emergency procedures" and "evacuation procedures". The new hire orientation checklist did not list other type of emergency procedures as part of their orientation such as missing person. Additionally, staff training documentation review revealed that missing person, or elopement, procedures were not covered at the time of hire although there was evidence from documentation that facility does provide missing person training later during the hire year. Missing person procedures are not reviewed with staff during the initial orientation. An interview with E2 (DON) on 5/25/11 confirmed that missing person	F 518		

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F 518	Continued From page 43	F 518		

procedures were not reviewed with staff during their initial orientation. The six staff included the following:

1. E7 (CNA) hired on 2/12/11 had fire and evacuation training upon hire only and was missing other type emergency preparedness training.
2. E29 (RN) hired on 5/1/11 had fire and evacuation training upon hire only and was missing other type emergency preparedness training.
3. E30 (CNA) hired on 2/23/11 had fire and evacuation training upon hire only and was missing other type emergency preparedness training.
4. E31 (CNA) hired on 5/10/11 had fire and evacuation training upon hire only and was missing other type emergency preparedness training.
5. E32 (Housekeeping) hired on 3/30/11 had fire and evacuation training upon hire only and was missing other type emergency preparedness training.
6. E33 (LPN) hired on 4/11/11 had fire and evacuation training upon hire only and was missing other type emergency preparedness training.

Review of the facility emergency procedures revealed that the procedure did not include all types of emergencies appropriate for this facility such as hurricane, bomb threat, tornado, flood, electrical and water emergencies. An interview with the E18 (Food Service Director) on 5/25/11 revealed that the dietary manual did cover some emergencies but that this manual was not part of the facility training for new hires.

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F 518	Continued From page 44 The facility failed to train staff upon hire in all emergency procedures. On 5/25/11, findings were confirmed by E22 (Training Coordinator/Social Service).	F 518		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLETED: May 26, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from May 15, 2011 through May 26 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 59. The survey Stage II sample totaled twenty-nine (29) residents.	Please refer to CMS 2567-L F156,f164, F208, F225, F246, F253, F323, F325, F371, F372, F431, F441, F463, F466, F467, F518. 7/29/11
201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **The requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 5/26/11, F156,	

Provider's Signature [signature] Title Administrator Date 7/1/11

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STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLETED: May 26, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	F164, F208, F225, F246, F253, F323, F325, F371, F372, F431, F441, F463, F466, F467 and F518.	
3201.7.5	**Kitchen and Food Storage Areas** **Facilities shall comply with the Delaware Food Code.** **Managing Exclusions and Restrictions** **2-201.13 Removal, Adjustment, or Retention of Exclusions and Restrictions.** The person in charge shall adhere to the following conditions when removing, adjusting, or retaining the exclusion or restriction of a food employee: (A) Except when a food employee is diagnosed with an infection from Norovirus diagnosis adjusting exclusion for food employee who was symptomatic and is now asymptomatic (2) If a food employee was diagnosed with an infection from Norovirus and excluded as specified under Subparagraph 2-201.12(A)(2); (a) Restrict the food employee, who is asymptomatic for at least 24 hours and works in a food establishment not serving a highly susceptible population, until the conditions for reinstatement as specified under Subparagraphs (D)(1) or (2) of this section are met; or retaining exclusion for food employee who was asymptomatic and is now asymptomatic and works in food establishment serving HSP (b) Retain the exclusion for the food employee, who is asymptomatic for at least 24 hours and works in a food establishment that serves a highly susceptible population, until the conditions	

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	for reinstatement as specified under Subparagraphs (D)(1) or (2) of this section are met. Cross refer to the CMS 2567-L survey report date completed 5/26/11 Cross refer to F371, Example 4. **3-301.12 Preventing** **3-301.11 Preventing Contamination from Hands.** (A) Food employees shall wash their hands as specified under § 2-301.12. (B) Except when washing fruits and vegetables as specified under § 3-302.15 or as specified in ¶ (D) of this section, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (C) Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form. (D) Food employees not serving a highly susceptible population may contact exposed, ready-to-eat food with their bare hands if: (1) The permit holder obtains prior approval from the regulatory authority; (2) Written procedures are maintained in the food establishment and made available to the regulatory authority upon request that include: (a) For each bare hand contact procedure, a listing of the specific ready-to-eat foods that are touched by bare hands. (b) Diagrams and other information showing that hand-washing facilities, installed, located, equipped, and	

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	maintained as specified under §§ 5-203.11, 5-204.11, 5-205.11, 6-301.11, 6-301.12, and 6-301.14, are in an easily accessible location and in close proximity to the work station where the bare hand contact procedure is conducted; (3) A written employee health policy that details how the food establishment complies with §§ 2-201.11, 2-201.12, and 2-201.13 including: (a) Documentation that food employees and conditional employees acknowledge that they are informed to report information about their health and activities as they relate to gastrointestinal symptoms and diseases that are transmittable through food as specified under ¶ 2-201.11(A), (b) Documentation that food employees and conditional employees acknowledge their responsibilities as specified under ¶ 2-201.11(E) and (F), and (c) Documentation that the person in charge acknowledges the responsibilities as specified under 2-201.11(B), (C) and (D), and sections 2-201.12 and 2-201.13; (4) Documentation that food employees acknowledge that they have received training in: (a) The risks of contacting the specific ready-to-eat foods with bare hands, (b) Proper hand washing as specified under § 2-301.12, (c) When to wash their hands as specified under § 2-301.14, (d) Where to wash their hands as specified under § 2-301.15, (e) Proper fingernail maintenance as specified under § 2-302.11, (f) Prohibition of jewelry as specified under § 2-303.11, and (g) Good hygienic practices as specified under §§2-401.11	

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	and 2-401.12; (5) Documentation that hands are washed before food preparation and as necessary to prevent cross contamination by food employees as specified under §§ 2-301.11, 2-301.12, 2-301.14, and 2-301.15 during all hours of operation when the specific ready-to-eat foods are prepared; (6) Documentation that food employees contacting ready-to-eat food with bare hands use two or more of the following control measures to provide additional safeguards to hazards associated with bare hand contact: (a) Double hand washing, (b) Nail brushes, (c) A hand antiseptic after hand washing as specified under § 2-301.16, (d) Incentive programs such as paid sick leave that assist or encourage food employees not to work when they are ill, or (e) Other control measures approved by the regulatory authority; and (7) Documentation that corrective action is taken when Subparagraphs (D)(1) - (6) of this section are not followed. **3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding.** (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food (time/temperature control for safety food) shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130°F) or above;	

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	Cross refer to the CMS 2567-L survey report date completed 5/26/11, F371, examples 1, 2, 3. **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units for refuse and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.** Cross refer to the CMS 2567-L survey report date completed 5/26/11, F372.	
16 Del. C., Chapter 11, Subchapter VII, §1162	**Nursing Staffing** (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:	

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	RN/LPN CNA* Day 1:15 res. 1:8 res. Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. Three (3) weeks of facility staffing, covering the period of 24 April 2011 through 14 May 2011 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Newark Manor staff, and signed by the Administrator. The seven (7) citations hereon result from that work. **The law was not met as evidenced by:** Newark Manor failed to meet the 3.28 Daily Care Hours per Resident on the seven (7) dates below. The per resident care hours attained by the provider on each day are parenthesed. 1. Sunday, 24 April 2011 (3.18). 2. Saturday, 30 April 2011 (3.25). 3. Sunday, 1 May 2011 (3.21). 4. Friday, 6 May 2011 (3.26). 5. Saturday, 7 May 201 (3.25). 6. Sunday, 8 May 2011 (3.20). 7. Saturday, 14 May 2011 (3.24).	The facility is in full compliance with 3.28 hours of direct care. There were no deficient staffing issues found. Additional staff was added and remained scheduled. The Director of Nursing, who schedules the Nursing staff, received additional education calculating staffing and meeting staffing requirements. The Administrator will monitor staffing weekly and will report any variances to the QA Committee.